VOL. 16, NO. 2 OCT.-DEC., 1966

Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physicial examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $75 in cash or certified check only must be paid at the time of admission. No personal checks can be accepted! Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

R. J. BLACKLEY, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

OCTOBER-DECEMBER, 1966

VOLUME 16 NUMBER 2

RALEIGH, N. C.

Aneducational Journal on Alcohol and Alcoholism. Published quarterly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 2100 Hillsboro St., Raleigh, North Carolina, 27607.

LILLIAN PIKE
Editor

ELEANOR BROOKS
Circulation Manager

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request, with the exception that *new* requests from *individuals* residing outside North Carolina can no longer be accepted. The views expressed in articles published in *Inventory* are those of the authors and not necessarily those of the NCARP. Manuscripts are invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina 27603.

SECOND-CLASS POSTAGE PAID AT RALEIGH, N. C. 27602

Needed:

AN ASSAULT ON ALCOHOLISM

BY FRED W. ELLIS, Ph.D., M.D.

The assault on alcoholism should include an assault on the legal, social, moral and economic problems which result from the acute effects of alcohol on the mind and body.

Published by permission of the author, this article is based on an address presented at a meeting of the North Carolina Association of Boards of Alcoholic Control which was held February 16, 1966 in Durham. Dr. Ellis is a professor of pharmacology at the School of Medicine of the University of North Carolina.

THE ingestion of alcohol is an ancient custom which goes back at least as far as the recorded history of man's activities. It has been part of the culture of primitive as well as civilized people throughout the world. In the United States today the consumption of alcoholic beverages is commonly practiced as a gesture of hospitality and a symbol of festivity to enliven social occasions. For many people it is intimately related to religious and civil ceremony; for many it holds a prominent place in our social mores. In medicine it occupies a limited place as a therapeutic procedure. Nothwithstanding the various possible useful properties that different groups may attribute to alcohol, popular opinions of its effects on human functions and affairs are often clouded by facetiousness and ignorance based on traditions handed down from the past. Alcohol has brought untold difficulties, personal and social, on its unsuspecting users through their abuse and misuse of this agent. In fact today, many of our most serious and troublesome legal, medical and public health problems are derived from alcoholism and the excessive consumption of alcohol.

What do we mean by ALCOHOLISM? Usually the term is employed in a narrow sense to refer to a "condition" which exists when an excessive drinker can not control his habit. In this sense often the victim is viewed in the community as one who possesses a "weak character" or is of "low moral fiber." This concept no longer is tolerable. This type of alcoholism—*chronic alcoholism*—is a disease. But what about alcoholism in a general sense? Alcoholism, in my opnion, should also include the various degrees of acute effects of alcohol on the mind and body. It should include those alcohol effects which result in increased accident

proneness, reckless driving on our highways, and many legal and economic difficulties, as well as certain moral and social problems in general.

The extent of these problems may be inferred by the following statistics. It is estimated that 65 to 70 per cent of the adult population in the United States (above 15 years of age) uses alcohol to some extent. It is estimated that of these users *1 out of 12* becomes chronically ill from its use. Approximately 6,500,000 such victims are in the U. S. society today. Furthermore, it is thought that we can expect an additional 200,000 chronic alcoholics annually unless effective ways to prevent this disease are invoked.

Since some of the control duties and responsibilities of Alcoholic Beverage Control Boards are related to public "education as to the effects of alcohol," enforcement of laws governing its use and concerns for rehabilitation of the alcoholic sick, it is my intention to discuss now certain areas of alcoholism in general in which I think great strides could be made through a united assault on this problem. My approach is one of *CONTROL*—not opposition.

Vigorous Campaign in Alcohol Education. In view of the aforementioned widespread use of alcohol in our society, everyone should know about the possible effects of this substance on the mind and body and the consequences of its abuse. There should be an organized campaign to *treat our respective communities with facts about alcohol.* In many instances there is reluctance to discard old attitudes and prejudices about drinking and alcoholism. Many are unwilling to face the fact that chronic alcoholism is a disease and that each community has a responsibility to help solve problems stemming from it. This type of assault would have to be planned carefully and organized well to be effective. Perhaps it would involve local community seminars, public discussion, local television and radio programs and authoritatively written newspaper articles and pamphlets. Such an assault would be a welcome supplement to the very fine efforts currently carried on by the Education Division of the North Carolina Department of Mental Health and the local alcohol information centers, and to the woefully inadequate public school instruction which, by my observations, is only taken in order to respect the state statute requiring such instruction.

What should we teach about effects of alcohol?

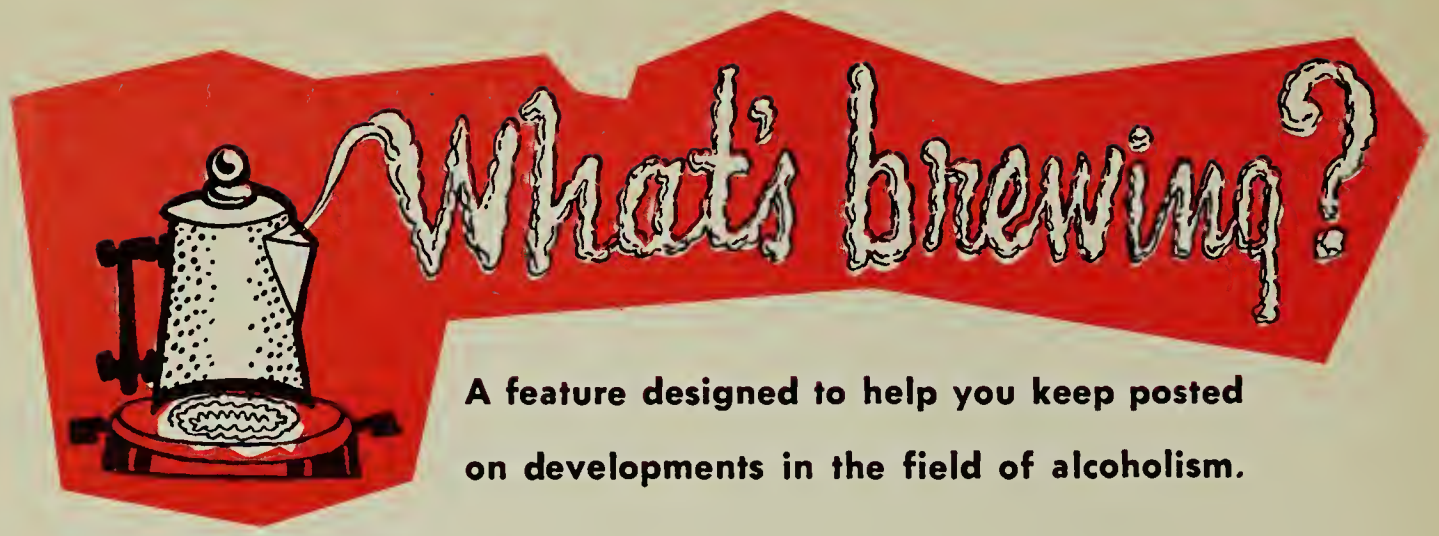
. . . that ethyl alcohol, a depressant to the brain and nervous system, is *THE* responsible substance for intoxication in all alcoholic beverages and that essentially the same effects will be produced in a given person by "unit" drinks of 12 ounces of beer, 3½ ounces of wine (14%) and 1 ounce of distilled liquor (90 proof).

. . . that alcohol is rapidly absorbed into the blood stream (especially if taken on an empty stomach) but is slowly eliminated from the body. Hence it is easy to accumulate intoxicating blood-alcohol (and brain) levels.

. . . That about 2/3 of the weight of a human body is water and any amount of alcohol taken into the body will be diluted in this volume of water which is the principal determinant of blood-alcohol concentration. On this basis and with one's body weight known, a person can be taught what approximate blood-alcohol levels can be expected from ingesting known amounts of alcohol.

. . . that the average maximum

(Continued on page 6)



RALEIGH, N. C.: "Communication: In Health and Disease" will be the theme of the fourth annual John W. Umstead Series of Distinguished Lectures to be given in Raleigh, N. C. at the Sir Walter Hotel February 2 and 3, 1967. On both days the morning and afternoon programs will begin at 10:00 a.m. and 2:00 p.m. The lecturers are as follows: Robert Haakenson, Ph.D., Smith, Kline & French Laboratories; Bernard Glueck, Jr., M.D., Institute of Living, Hartford, Connecticut; Gilbert Gottlieb, Ph.D., Division of Research, N. C. Department of Mental Health; Harold P. Holder, Ph.D., Department of Journalism, Baylor University; Martin Orne, M.D., Department of Psychiatry, University of Pennsylvania; Charles F. Reed, Ph.D., Department of Psychology, Temple University; Peter Marler, Ph.D., Department of Zoology, Rockefeller University; and Peter N. Witt, M.D., Division of Research, N. C. Department of Mental Health. The series is sponsored by the N. C. Department of Mental Health, the N. C. Mental Health Association, and the N. C. Medical Society.

CHAPEL HILL, N. C.: The Department of Psychiatry, School of Medicine, and the School of Public Health of the University of North Carolina have announced a joint advanced training program in community mental health. The program is being offered to psychiatrists, psychologists, social workers, nurses, administrators, social scientists and others who are preparing for leadership or clinical positions in mental health centers, state or local programs. Successful completion of one year of training will merit a Certificate in Mental Health Program Administration. Successful completion of two years of training, including further field practicum, administrative apprenticeships, seminars in social psychiatry and completon of a major in a department of the School of Public Health, provides eligibility for a Master of Public Health degree. Part-time programs can be negotiated.

Individual training goals can be met through special curriculum planning. Tutorial, didactic and practicum teaching will be provided by an experienced faculty of psychiatrists, psychologists, epidemiologists, biostatisticians, public health administrators, social workers, psychiatric nurses and social scientists. The curriculum will include courses on: Leadership and Administration, Analysis of Mental Health Programs, and Research and Theoretical Foundations of Mental Health Programs.

A limited number of stipends, the level of which will be graduated according to the seniority and discipline of the trainee in accordance with accepted University and National Institute of Mental Health Standards, are available. Early applications are encouraged. Further information and application forms may be obtained by writing: Dr. William G. Hollister, Department of Psychiatry, School of Medicine, University of North Carolina, Chapel Hill, N. C. 27514.

RALEIGH, N. C.: Around 100 people met with the N. C. Department of Mental Health on December 21 at Dorothea Dix Hospital in Raleigh to discuss the present and projected alcoholism programs of the department. In addition to members of the Alcoholism Programs of North Carolina, representatives of mental health clinics, the state mental hospitals, the state prison, probation and parole systems, the medical and social service professions, legislators and others were present. The group agreed to support legislation for retaining the nickel-a-bottle price increase on State ABC Store products for use in alcoholism rehabilitation programs. A committee, with APNC President Marshall Abee as chairman, was appointed to work with the department in clarifying questions left unresolved at the meeting and to make recommendations at a follow-up meeting of the entire group, probably in early February, 1967.

1967 FELLOWSHIPS: The James S. Kemper Foundation has announced that it is offering four fellowships for occupational health nurses in business and industry to each of the following summer schools of alcohol studies: University of Utah, School of Alcohol Studies, P. O. Box 473, Salt Lake City, Utah 84110 (June 18-23); Northeast Institute of Alcohol Studies, Center of Alcohol Studies, Rutgers—The State University, New Brunswick, N. J. 08903 (July 16-21); University of Texas, Institute on Alcohol Studies, Scholarship Committee, 808 Sam Houston Office Bldg., Austin, Texas 78701 (July 16-21); International School of Alcohol Studies, University of North Dakota, Grand Forks, N. D. in care of Bernard Larsen, Director, North Dakota Commission on Alcoholism, Bismarck, N. D. 58501 (July 23-28); and Southeastern School of Alcohol Studies, William J. McCord, Director, Room 1104 Rutledge Office Bldg., 1429 Senate Street, Columbia, South Carolina 29201 (August 13-18).

The awards will cover tuition, room and board and the recipients will be selected by each school from those submitting applications no later than 60 days prior to the opening date. Application blanks and more detailed information may be secured by writing the school nearest you.

The above general rules apply also to six fellowships for teachers in schools of nursing in the United States and Canada being offered by the foundation for the three-week specialized training courses (June 25-July 14) at the Center of Alcohol Studies, Rutgers—The State University, New Brunswick, N. J. 08903.

SPRINGFIELD, ILLINOIS: A series of eleven films on alcoholism have been produced by WTTW-TV in cooperation with the Illinois Division of Alcoholism with funds from a Federal grant provided by the Vocational Rehabilitation Administration. After their original showing on WTTW--TV beginning November 16, 1966 and continuing each Wednesday thereafter for a ten-week period the films will be available to other television stations and for use at community educational meetings. They deal with the subjects of alcoholism, rehabilitation and methods for coping with problems of alcoholism. For information on how to obtain the films, write: William N. Becker, Jr., Assistant Chief, Division of Alcoholism, 401 State Office Bldg., Springfield, Ill. 62706.

The theme of the series is "Alcoholics Are People." The individual programs carry the following titles: The Roots of the Problem, Tuesdays at Three, Toward Recovery, I've Had It, The Billion Dollar Hangover, Alcoholism Makes It Tougher, The First Stone, Address Nowhere, The Not Very Merry-Go-Round, The Not Yet Alcoholic, and Where Now?

hourly capacity of the body to get rid of alcohol is approximately equivalent to the alcohol contained in 12 ounces of beer, 3½ ounces of wine or 1 ounce of distilled liquor and that this rate of elimination changes the per cent of blood-alcohol concentration by hourly decrements of only about 0.015.

. . . that blood-alcohol levels of about 0.05 per cent (produced in a person weighing about 150 pounds by 2 "unit" drinks as defined above) have been shown by experiments to impair judgment decisions, affect vision, and interfere with refined neuromuscular coordination in one-third or more of subjects tested. Thus significant effects of alcohol are not dependent upon manifestations of overt signs and symptoms of gross intoxication. Hence, automobile driving ability and performance of other refined skills may be impaired at blood-alcohol levels considerably below those conventionally interpreted to mean "under the influence" of alcohol.

. . . that tolerance to alcohol occurs whereby more and more beverage is necessary to provide the subjective effects initially experienced and that insidious development of dependence, psychological and physical, upon alcohol definitely occurs to produce a state of addiction, which can be demonstrated by withdrawal symptoms (in a "true" alcoholic).

Revision of Legal Concepts and Legislation. Chronic alcoholics are defined by health and medical agencies as victims of a disease. The *World Health Organization* defines alcoholics as "those excessive drinkers whose dependence upon alcohol has reached such a degree that it results in noticeable mental disturbance or in an interference with their bodily and mental health, their smooth social and economic functioning or those who show the prodromal signs of such development." The *National Research Council* says "an alcoholic is a person who is powerless to stop drinking and whose drinking seriously alters his normal living pattern." We need to know that chronic alcoholism is a bio-psycho-social disease in which the alcoholic has an uncontrollable craving to drink alcohol. Chronic alcoholism is the fourth major health problem in our society, being out-ranked only by mental illnesses, heart diseases, and cancer, and who knows what role alcohol may play in the causation of these?

Now, it has been common practice for the courts to treat these ill victims as criminals, especially for violating laws of public drunkenness. There is obviously a need for a new concept and revised legislation in the handling, treatment and rehabilitation of these people.

Dawn of a New Day

Fortunately the dawn of a new day in this regard appeared recently when the U. S. Court of Appeals in Richmond ruled that a chronic alcoholic (who is a citizen of North Carolina) could not be arrested and treated as a criminal, although he might be detained for medical treatment. This court action, on appeal, reversed lower court convictions of this person who had been sentenced to prison many times previously for public drunkenness.

Two serious implications are apparent here: North Carolina laws should exclude known chronic alcoholics from criminal prosecution for an illness over which they now have no control, and simultaneously, the state must provide additional treatment and rehabilitation facilities for them. Funds should be provided and expended on planning and con-

struction of treatment and research facilities so that better alternatives than custodial jails and punitive prison camps should be available to the courts in disposing of charges against alcoholics brought before them.

Drunken Driving. In a highly mobile society, such as ours in which a large segment of our adult population consumes alcoholic beverages to some degree, it may not be a surprising fact, although it is certainly an inexcusable one, that a high proportion of the motor vehicles on our highways are operated by drinking drivers.

Accident facts published by the National Safety Council indicate that drinking drivers are involved in over 50 per cent of fatal accidents on our national highways. In single car accidents, some state surveys go as high as 62 per cent! In 1965 about 49,000 people in the United States met their death in highway accidents. This means about 25,000 deaths in which drinking drivers were involved.

Surely there needs to be an assault on this problem. It has been generally held that a *chemical test law* within a given state would act as a psychological deterrent to "drunken driving" and aid in the prosecution of offenders of the law. As of July 1, 1965, 40 states in the Union had such laws on their statutes, including North Carolina (as of 1963). However, all of these laws are based on the concept that a specified blood-alcohol concentration of either 0.1 per cent or 0.15 per cent is the level at which a driver is presumed to be under the influence of alcohol.

In my opinion, there are two objections to this type of legislation: it is difficult to obtain prosecution in many instances when functional evidence of intoxication cannot be proved, and the permissible blood-alcohol level is too high. Evidence obtained in several surveys indicates that the *actual driving ability* of a high percentage of drivers is significantly impaired over the wide range of 0.03-0.07 per cent blood-alcohol level. The literature on this topic is almost unaminous in its conclusions that driving skills begin to deteriorate at about 0.05 per cent. (Perhaps it will be recalled that in a 150-lb. man more than 4 beers, 3/4 pint of wine or 4 ounces of distilled beverage are required to attain a blood-alcohol level of 0.1 per cent!)

Recently a new study of actual driving performance of drinking and non-drinking and accident-involved and non-accident-involved drivers revealed the following relationships:

Results of Study

(1) A blood-alcohol level over 0.04 per cent is definitely associated with an increased accident involvement. (Those with 0.04 per cent or below are about as likely to cause accidents as completely sober drivers.)

(2) When drivers with a blood-alcohol level over 0.08 per cent have accidents, they tend to have more single vehicle accidents, more severe (in terms of injury and damage) accidents, and more expensive accidents than similar sober drivers.

(3) When the blood-alcohol level of 0.06 per cent is reached, the estimated probability of the driver causing an accident is *double* that of a driver with no alcohol.

(4) Drivers with 0.1 per cent alcohol in their blood are more than six times as likely to cause accidents as those with no alcohol.

(5) When the 0.15 per cent blood-alcohol level is reached, the probability of an accident occurring is increased to more than *25 times* that of the sober driver.

What shall we do about this situation? In my opinion there is a clear indication here that *an assault* on this problem should be made. I believe that the concept of "driving under the influence of alcohol" should be abandoned and that a newer approach to the control of this problem should be based on the principle of "impaired driving ability." I should like to *urge the passage of new legislation which would make it illegal for a driver to operate a motor vehicle on the highways of North Carolina with a blood-alcohol level in excess of 0.05 per cent.* This type of legislation would be comparable to our speed laws, which if violated cannot be compromised in court by the argument that a given driver can drive safely at a higher rate of speed than that legally permitted. The number of people who exhibit a significant degree of impaired driving ability with alcohol is great enough to justify a rigid legal restriction of 0.05 per cent blood-alcohol level for *all* drivers! On this basis no argument would be permitted as to whether the driver was or was not "under the influence" of alcohol.

Multidiciplinary Research Program. Finally, in order to gain much needed new information about alcoholism—its controlled use, chronic alcoholism, altered concepts, aspects of cause, treatment and rehabilitation of alcoholics—we should initiate a well-planned multidisciplinary research program. There are many problems to be investigated, many questions to be answered. Throughout the concept of such a program would predominate the idea of *CONTROL* of the problems—not eradication of the use of alcohol. Complete elimination would require elimination of people or alcohol, or both. The answer to this situation is obvious.

It is recognized that movements are underway at the federal level to initiate a federally-sponsored alcoholism program. Also, it is acknowledged that Governor Dan K. Moore is on record as favoring: (1) improved facilities for treatment and rehabilitation of chronic alcoholics, (2) an expanded education program and (3) the possibility of establishing a research program.

About a year ago a "grass roots" group of interested persons from the University of North Carolina at Chapel Hill, Duke University, N. C. Department of Mental Health, Research Triangle Institute, and members of two or three A.B.C. Boards discussed the possibiilty of organizing an agency independent of, but in a close working relationship with, institutions of the triangle area and the State government, which could attract state, federal, and private funds, as well as support from A.B.C. funds. The research program would be broadly defined to include the following aspects: medical (both basic and clinical), *social-scientific* (economics, political science, psychology, and sociology), and *community organization-educational* (law enforcement, community development and welfare). This proposal was presented to Governor Moore for his preliminary consideration. Through a variety of circumstances, no followup to this proposal has taken place. I should hope that the idea might appeal to A.B.C. Boards and that some impetus to, and influence on, the suggestion might be engendered through their interest in helping to solve problems related to alcohol use and alcoholism in general. There is great need for new information on better understanding of problems related to use of alcohol. Only scientific research will provide the answers which are needed.

Alcoholism rehabilitation is a responsibilty of the community, too, not just the State alone.

BY THE REVEREND JOSEPH L. KELLERMANN

COMMUNITY RESPONSIBILITY IN Alcoholic Rehabilitation

THERE are several basic facts which require the community to become responsible in alcoholism rehabilitation.

One: The size and scope of the problem is entirely too large for a state program. No state program in our country is capable of treating more than a tiny percentage of persons who need therapy.

Two: Specialized treatment, or treatment of a special nature, can be administered in a state hospital or alcoholic rehabilitation hospital outside the patient's own community. Recovery, however, begins when the patient returns home and can not occur until a sober adjustment can be made by the patient within the community. The time period of hospitalization should not be more than four to six weeks including detoxification. It should include diagnosis and evaluation, and a patient-specific post-hospitalization recovery program should be outlined prior to discharge of the patient.

Three: The post-hospital plan of recovery involves a period of two to three years if recovery is to be expected from a majority of patients. A weekly or biweekly activity designed to reinforce the alcoholic's capacity to overcome the compulsion to drink is basic to recovery. Such a program can not be provided

Published by permission of the author, this article is based on a talk given at the Western Regional Leadership Conference on Alcoholism on November 29, 1966 at Broughton Hospital in Morganton. The conference was one of four co-sponsored by the N. C. Department of Mental Health and the Alcoholism Programs of North Carolina. Rev. Kellermann is director of the Charlotte Council on Alcoholism.

by a state hospital. About five per cent of the persons who need help become active and successful members of Alcoholics Anonymous, primarily middle-class persons.

Four: Education and treatment of the family of the alcoholic initially, and on a continuing basis, is *more* important than treating the patient. Our state hospitals are designed to treat the addict on an interruptive, inpatient, away from home, treatment basis. They are not designed to give primary assistance to the family. Therefore they are able to produce lasting results for a small minority of patients only. Changing from a small minority rate of recovery to a large majority rate will necessitate an overall patient-family-community program which the state hospital can not provide.

Five: Effective use of a state hospital is dependent upon an orderly flow of patients from the local medical community to the state hospital and back into the local medical community. The state hospital system gives priority of admission to indigent patient as stated clearly in the General Statutes of North Carolina which established the hospital system. It also provides special care and long-range treatment which cannot be provided in communities. The overwhelming handicap in treating alcoholism as an illness is the fact that local medical communities do not accept and treat alcoholism as a normal illness. The orderly flow to and from the state hospital and community does not exist because most alcoholics and their families never get into the local medical community for medical treatment or counseling. Although a doctor must examine and recommend every patient admitted voluntarily to a state hospital and two doctors must examine persons entering on medical certification or judicial admission, this in no way means the alcoholic and family are bona fide patients under treatment of the physician. Such medical service is often on an a la carte basis or cafeteria style medical service. Medical services locally are used primarily as a means of gaining admission to the hospital, not as a preparation for admission and a long-range follow-up program of rehabilitation.

In simple language, there is an enormous gap between the private practice of medicine and the state hospital system. The two live in separate worlds and speak to each other through committees. In fact the relationship between a practicing physician and a local general hospital is a rather tenuous situation in which the hospital provides temporary special services while the doctor treats the patient for an acute or severe condition. The general hospital theoretically has a responsibility to the patient after release from the hospital, but in reality the arrangement between the doctor and the patient is a private contract which the patient can terminate at any time and which the doctor may terminate when the acute medical condition is over. Recovery from alcoholism simply does not lend itself to such medical practice but this is reality. Unless the community assumes its responsibility for long-range rehabilitation programs, *they will not exist*. If they do not exist, the family and patient will be deprived of necessary rehabilitation services for a majority of patients who return from state hospitals plus the overwhelming majority of alcoholism families who never get to a state hospital or treatment center.

that alcoholics cannot be helped until they want help.

Six: Purely voluntary rehabilitation efforts on the part of the alcoholic are almost wholly futile. The alcoholic has found the best method of treatment of alcoholism known to mankind—simply getting drunk. Alcoholism is the only disease known to man named for the self-administered patent medicine prescribed by the patient. Drunkenness or the repeated excessive use of alcohol is not the illness. The disease is the heartache which the patient attempts to relieve by overdrinking which in effect is a form of overmedication. In reality, alcoholics do not drink but consume alcohol as a medicine. This is their treatment and their voluntary effort to rehabilitate themselves. A structured program must be established with legal, social and industrial employment disciplines built in to make the program work. It is simply untrue that alcoholics cannot be helped until they want help. A better answer must be offered than they find in the bottle and the community must be prepared to allow the consequences of drinking to become far more painful than the pleasure of alcoholic escape if rehabilitation is to be accomplished. Allis-Chalmers, DuPont, Consolidated Edison and many others have shown amazing results when this principle was applied to alcoholic employees. If, however, the employer is to have resources to supplement motivation by the exercise of company discipline, a community recovery program must exist. The family, too, must have resources for continued help if they are to enter into long-range therapy. Today the results of Al-Anon are just as dramatic as the results of Alcoholics Anonymous were nearly a generation ago. Many husbands accept the A.A. program after the wife has had six months or more of beneficial help from group participation in Al-Anon, but not more than one or two per cent of those who need it get into this group.

Seven: The entire area of involuntary treatment on a local outpatient or daycare basis must be explored. Most judicial admissions are effected because there is no involuntary or judicial channel open to the family until the chronic or addictive stage of the illness is completely manifest. This means that 15 to 20 years of untreated alcoholism transpires before treatment can be initiated by some one other than the patient if voluntary medical practice is to be used. Pre-hospital, or post-hospital care, voluntary or involuntary, can be provided by the community if properly organized and structured. The provision of the involuntary services on this basis, while protecting the constitutional civil rights of the patient, would do far more to reduce alcoholism than any state hospital program. The basic difficulty here is the overall lack of knowledge in the field of alcoholism which fails to distinguish between drinking too much socially and a disease entity termed alcoholism. Every man or woman has the right to drink, even if they are known alcoholics. However, if drinking interferes with the responsibilities of the individual to the family or injures society, involuntary treatment is indicated. Few persons are aware of the fact that our present judicial hospitalization of the alcoholic can be made for the benefit of the family as well as that of the patient. A very real paradox is the fact that civil commitment is

(Continued on page 24)

This article was given as a talk at the South Central Regional Leadership Conference on Alcoholism, one of four sponsored by the N. C. Department of Mental Health and the Alcoholism Progams of North Carolina, on November 18, 1966 at Dorothea Dix Hospital in Raleigh. Abee, a former director of a local alcoholism program, is presently director of Community Health Services, Inc. of Greensboro.

BUILDING

ALTHOUGH I have been asked to share with you some thoughts on the broad topic "Building Programs to Close the Gaps", it would be highly presumptuous of me if I tried to tell you what *your* community needs to close the gaps. So rest assured, I am not going to alienate myself at the onset by pretending to know your community better than you.

First, let us agree on a common understanding of this topic. What do we mean "Building Programs to Close the Gaps?" *"Building"* is an action word and I think we can all agree that we need more of it directed toward alcoholism in each of our communities. *"Programs,"* you will note, is plural, so we are talking about more than one. This word to me indicates well organized plans developed with specific purposes in mind. As it is used here, we are talking about more than one plan to meet more than one problem. Although the plans and problems obviously must be related, the groups involved may be different, thus often requiring separate and unique approaches.

Webster gives us several meanings for the word *"close."* The one which fits our subject best might be, "To bring the parts together." This is really the basic challenge. When you return to your communities from this conference, you are the ones who can initiate the action needed to bring agencies and people together to attack the alcoholism problems in your community. I should be using the word "we" for the task of "bringing the parts together" in our respective communities must be widely shared. Finally, for the word *"Gaps,"* —we could accept notch, breach, or chasm but these are not descriptive enough for our purpose. The meaning which clearly describes one of the most serious problems in the treatment of alcoholics is, as quoted from Webster, "A break in continuity." Here is another challenge which every community across our State must consider immediately, that of improving the continuity of care, not only for alcoholism but for other illnesses as well. I have already contradicted myself, haven't I? I said I wasn't going to tell you what your community needs. I haven't really, for better communications between agencies, resulting in improved continuity of care, is a need in my community and yours.

In my further remarks, I propose to discuss with you the need for strong community action. I will review with you some of the basic principles for working with people which, if followed, can and have produced gratifying results in many communities. I want also to caution you about one of the big pitfalls in developing or building community programs. Then, finally, perhaps we can raise some questions which might be helpful to you in the discussion period here at the conference as well as with your fellow citizens at home.

Sooner or later, most of us become concerned about changes taking place in our communities or changes we want to bring about. I suppose that is why many of you have spent the

Intense citizen participation throughout the state is needed if the concepts about alcoholism we have developed in the past few years are to take root universally.

By MARSHALL ABEE, M.P.H.

Programs to Close the Gaps

entire day here discussing alcoholism and its related problems. By your attendance at this conference, you are expressing your genuine concern about this perplexing illness. I trust that you are also demonstrating your willingness to become actively involved in our efforts to stimulate community action across the State.

There are certain factors concerning the public and alcoholism which, if recognized and taken into consideration, can effectively assist us in developing community programs to fill the gaps. We need to realize that there have been built up in both drinkers and in non-drinkers alike, definite attitudes and opinions which may or may not be conducive to our concept and full understanding of alcoholism as an illness. These may be so concrete, so reinforced by highly emotional feelings about beverage alcohol that the establishment of an objective viewpoint becomes a difficult task. There are those who have developed an apathy toward alcohol. There are persons who have decided to drink or not to drink and having no personal problem as a result of this decision, believe that their responsibility ends there. To create an acceptance of our program, it is necessary to overcome false, biased ideas.

These facts are not discouraging, actually they present a challenge. It becomes apparent that the reconstruction of such attitudes is an undertaking which calls for action on the part of a large group of representative citizens. It logically follows that this type of voluntary community organization can become an actuality only in the event that the community is fortunate enough to have among its citizens a few persons with the instincts of promoters, the ingenuity of diplomats, and the vision of crusaders. You may very well be such a person and most likely you know others in your community. It will be to your great advantage if you recognize and accept the fact that you can't do the job by yourself. It is vitally important that we enlist citizen participation. Not just by name, but active participation. These are the people who will supply initiative, the aggressiveness, the vision, the sense of values and the adaptability which together can result in successful achievement. We have witnessed the strong action of voluntary organizations in the form of temperance unions — strongly supported by real crusaders in many localities, they have always been staunch citizens with a will to succeed. We all recognize the spirited forcefulness of these volunteer groups. If the concepts about alco-

holism which we have developed in the past few years are to take root universally, no longer clouded with foggy notions and misconceived attitudes, then throughout our state a similar intensity of citizen participation must be developed in the field of alcoholism.

Now that we have impressed upon you the importance of working with people for community action on alcohol problems . . . How does one go about working successfully with people? For most of you, I will not be revealing anything new, but let us consider this a review in the principles of working with people for all of us.

If you want a person to help carry out a project, let him help plan it. Perhaps no poem was ever written with greater feeling than these few lines portray:

I'm just like other man,
I like the things I help to plan;
The folks that tell us what to do
Make me as mad as they do you.

Credit is like a bacillus. It grows by division. If you are generous, you will want to give others the credit for what is accomplished. If you seek credit for yourself, you must give it to others. If you do, they will have to hand it back to you. If you don't, they will take it away from you. You are after results, not credit.

Expect the best of everyone. If you expect a man to be big and he is little, he is embarrassed. If you expect him to be little and he is big, you are embarrassed.

Straighten out grievances immediately. Do not let them grow. "Let not the sun set upon your wrath."

The best way to get rid of an enemy is to make a friend of him.

A group can make a better plan than the best expert in the group. "Everybody knows more than anybody." Persons of varied interests

Responsibility for a significant

make the best community action groups. "Special interests" are likely to appear. Do not allow them to dominate the collective planning of the group.

Avoid emotional tension; it is highly contagious. Relax. Hang on to your sense of humor. If tension crops up, find the cause of it and weed it out.

Don't write letters when you can phone; don't phone if you can make a personal contact.

One friend on the inside is worth many on the outside in gaining the interest and active cooperation of a group.

Don't forget the people who have helped you—they are an important reason for your success. Express your appreciation to all those involved.

Now that we have had our refresher course on the principles, let me caution you about the pitfall that all of us who work with people must be on guard against. This pitfall is to feel or act as though you were all alone. There are always others in the community who share your concern and will be willing to share in the action.

The quickest way to fall into the pit is to decide by yourself what is the problem calling for community action. If the action is to be successful, it must involve the other people who are concerned. But since action on any problem begins with the definition of it, the people who are to act must begin with defining the problem. This is not merely a technique of involving others in solving the problem as *you* diagnosed it. It is necessary for you to share the ideas of all the others to be quite sure that you know what the prob-

lem is. Anyone can be wrong, any group can be wrong, but the chances for successful community action are improved if all those concerned share in diagnosing the problem.

The next easiest way to fall into the pit is to prescribe the remedy by yourself. If the action in the community is to be successful, it must involve the other people who are also concerned. But since action on any problem begins with canvassing the various kinds of action that may be taken and assessing the probable results, the people who are to act must begin by making this canvass. This is not merely a technique of involving others in an action program. It is necessary for you to share the opinions of all the others in order to be quite sure that, within the limits of human frailty, you have canvassed all the possibilities. The chances for successful community action are better if all those concerned have shared in formulating the plan.

Well, we've talked about community action, how to work with people and the big danger to look out for. Now, let us assume that you have all these people keyed to a frenzy and chomping at the bit to get in to "where the action is." What are you going to ask them to do? One of the quickest ways to kill the initiative and interest of volunteers is to not have a meaningful job for them when they are ready to give you their time.

Perhaps finding the answers to some of these questions will provide much valuable work for your community action group.

Do you really know the extent of alcoholism problems in your community? Not based on an isolated case that you happen to know about personally. Have you talked with the social and health agency personnel to ascertain the size of the problem? Can you pin point one or two specific alcohol problems which appear to be of greater concern than others to your community?

Which of your community agencies or groups are actively interested in preventing alcohol problems? What methods are they using? Does your school system offer alcohol education? How is it taught? What grade levels? Are the teachers adequately prepared? How can your action group supplement and enhance the teaching which your schools, churches, and homes are now doing?

What group in your community will give your "action group" the best support? Do you anticipate any opposition? From whom? Are you prepared to meet the opposition, the indifference, the special interest manipulators, which may be in your community?

How will you sell the group-planned program to the agency leaders and to the elected officials who will have to provide some financing. What kind of federal and state funds might be available to your community? Are you going to be dependent upon such funds? Should you have an alternate, less expensive, plan in case your community must bear the full cost?

Will this conference be a success in more ways than numbers? You have the answer to this question. It will depend upon what you do back in your community. The citizens across our state must accept, at the community level, some of the responsibility for mounting a significant attack on our ever increasing alcohol problems.

Broughton Hospital's

By BILLY J. LINK, A.C.S.W.

Our operating philosophy is to offer the alcoholic patient the best possible help — the kind that may enable him to better help himself.

BROUGHTON Hospital has operated an alcoholic unit since October of 1963 when the policy regarding admissions of inebriates to the North Carolina mental hospitals was changed to provide for their treatment at each of the hospitals.

The unit since its inception has been oriented toward providing comprehensive care for the total patient. Every effort has been made to provide not only specifically structured modalities of treatment, but also a dynamic atmosphere of acceptance and day-in and day-out psychodynamically oriented personnel-patient relationships. This endeavor has required the cooperaton of all the personnel involved in the patient's care during his stay—the physician, clinical social worker, nurses and aides. For instance, each patient is interviewed and discussed in conferences at which all the personnel are acquainted with the total approach to that particular patient, e.g. utilizing the patient's everyday patterns of behavior to help bring him to some better understanding of how he is doing, or not doing, certain things—because of dependency needs, etc.

For this reason careful selection of personnel has been necessary. Every effort has been made to select personnel who are not handicapped by personal, openly hostile or ambivalent feelings regarding alcoholism. The selection of personnel who can view each day as a challenge in learning to understand the alcoholic and his problems and utilize that learning in all contacts with the patient has been the mainstay of this approach.

The Broughton Hospital Alcoholic Unit operates on the premise that alcoholism is not a disease entity in itself, but is rather the manifestation of specific psychological, sociological, and perhaps biochemical, maladaptations on the part of the patient. What is seen as alcoholism, then, is actually a "self-medication" on the part of the patient in his attempt to adjust to his internal and external conflicts—conflicts which he has not

At the time this article was submitted for publication, the author, Billy J. Link, was chief social worker of the Alcoholic Unit at Broughton Hospital. He now heads the Social Service Department at Cherry Hospital, Goldsboro.

been able to adjust to in a more mature manner.

With this as the premise around which the treatment approach revolves, close communication and liaison with local community agencies is constantly sought. Every effort is made to help educate and involve not only the alcoholic's family, but also the general public, public health workers, local physicians, social service agencies, ministers, A. A. groups and mental health facilities.

Our operating philosophy is to offer the best possible help for the alcoholic patient, but only the kind of help that may enable him to better help himself. We feel that this is the only philosophy that can offer the patient a nucleus for better future adjustment to dependency-independency conflicts. Physical restraints are never used nor do we feel they are ever justified.

Alcoholism Program

The unit has seventy-eight beds for the treatment of male and female inebriates. There are 60 male beds housed in a separate building and 18 female beds on Ward 202 of the general hospital area.

Its personnel consists of one full-time physician-director, one clinical social worker, one registered full-time nurse on each of the three shifts and psychiatric aides on all three shifts.

This patient-personnel ratio is deemed necessary because some 25 to 30 per cent of our new admissions are acutely intoxicated at the time of admission, chronically intoxicated, experiencing delirium tremens or impending delirium tremens, having acute hallucinosis, and/or acutely or seriously ill. This means that we operate a very active admissions ward with a rapid turnover, an acute hospital ward, and active treatment and rehabilitation service.

The scheduling of admissions to the alcoholic unit is handled by the admissions officer of Broughton Hospital. He sets a date and time for admission and this procedure does not differ from the one used for regular mental admissions. There are four types of admissions: medical certification, involuntary or commitment, voluntary and emergency.

The patient is brought to the admitting office upon admission. He is duly processed and then "checked in" by two attendants from the alcoholic unit. After the initial intake is completed, the patient is taken to the unit.

A 100 per cent admission service is offered for all admissions. The service includes an interview with the relative accompanying the patient. While the patient is being prepared for the ward, the social worker talks with his relative for the purpose of securing social history information. A comprehensive social service questionnaire is used as a guide for securing information. It covers almost all the phases of the patient's life, from birth until the present time. This gives the social

worker the opportunity to let the relative discuss the patient and in so doing, enables him to better evaluate the validity of the information being received. Following the completion of the questionnaire, the relatives are asked to discuss in detail the patient's particular problem and/or problems as they see them and casework services are offered to help them better understand the purpose of the patient's hospitalization; it gives them the opportunity to get first hand knowledge of the procedures involved in treating the patient. After the interview, the social worker from his notes on the discussion dictates a summary which is typed and forwarded to the physician for use in setting up a prescribed treatment program for the individual patient. Close liaision provides for quicker communication in special circumstances.

If a patient comes to the hospital unaccompanied by a relative, a letter and social history questionnaire are sent to the next of kin in an effort to better serve the patient and his family.

Another very vital part of the admission service is the follow-up visit with the newly admitted patient by the social worker. The main purpose of this visit is to meet the patient more formally and to assist him further with his admission to the hospital and the adjustments that this requires.

Once the patient has been taken to the unit, he is seen by the doctor who completes the physical examination which becomes a part of the patient's permanent record. As a part of the complete physical examination, the patient is scheduled—usually during his first days in the hospital—for X-ray, laboratory and dental examinations.

Clinical social worker conduct

After the patient has been hospitalized for a period of time felt to be sufficient for receiving maximum benefits from his hospitalization, he is scheduled for the disposition conference. If the patient is considered ready for release, a date is set for his discharge and a letter sent to his responsible relative informing him of the staff's decision.

It is felt that group psychotherapy is essentially the only structured psychotherapy of benefit to the alcoholic patient. Our program includes group psychotherapy sessions which are conducted by the clinical social worker each Monday through Thursday.

The group psychotherapy sessions begin with the Orientation Group on Monday which consists of all the newly admitted patients. This session is designed to help the patients with their admission to the hospital, to help them better understand the policies and procedures of the hospital, to explain the types of admission, and to offer them the opportunity to ventilate their feelings regarding the admission.

The Tuesday Group is designed to help the patient better understand the nature of his problem. Discussions are held around such topics as the steps leading to alcoholism and the acutely inebriated person. Participation in this particular session helps the patient to begin to discuss alcoholism and to begin to include himself in the group. This is basically the first step in leading the patient to take a look at himself and to think more concretely about his own individual problems and how they relate to his total life adjustment.

The Wednesday Group continues

group psychotherapy sessions each Monday through Thursday.

with the discussion of alcoholism and begins to lead the patient further into the objectives of, and what he can expect to result from, his hospitalization. This session is also utilized to allow other disciplines of the hospital—such as the recreation therapist, occupational therapist, vocational rehabilitation representative—which have dealings with the alcoholics during their hospitalization to discuss their services and the part they play in the overall treatment program. Among them, are the student nurses' affiliation with the unit and the physician's session on the "Effects of Alcohol on the Body."

The Thursday Group is designed to help the patient begin to think in terms of his release from the hospital and to help him arrive at more realistic goals and means of coping with reality problems. At this point in the patient's hospitalization he is thinking in terms of what he is going to do upon his return to the community, his family, his job, etc. In this group, we have open discussions, role playing, guest speakers, movies, etc. The patient in this session also receives his orientation to the various community agencies which are set up for the purpose of offering aftercare help to the returning patient.

Alcoholics Anonymous meetings are conducted twice weekly at our hospital and all patients are expected to attend each Tuesday night and Sunday afternoon. They are set up as a part of the patient's treatment program and are the one phase whereby the patients are able to participate in the program without members of the medical staff being present. This A.A. program was worked out through the local groups shortly after the opening of the alcoholic unit and has come to involve A.A. members from groups in a number of surrounding communities, including Charlotte, Gastonia, Hickory, Lenoir, Marion, Asheville, North Wilkesboro, Rutherfordton and others.

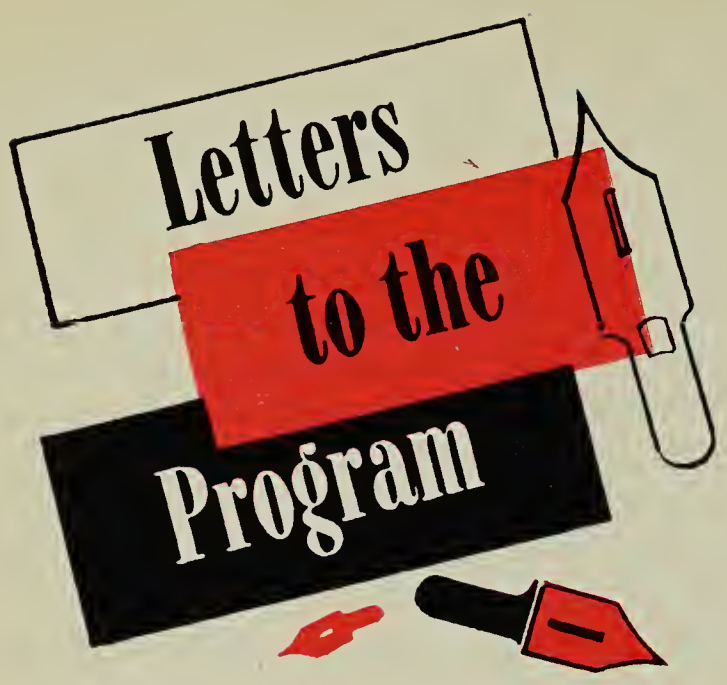
The patient who has a problem that needs individual consideration is seen privately by either the doctor or the social worker or by both. Oftentimes these problems involve family members and, if so, they are invited to the hospital to talk with us. Joint interviews are frequently held.

It is felt that industrial therapy, or some work assignment, should be a part of the patient's treatment program. As a general rule, alcoholics are assigned to work on one of the senile wards and/or on a yard detail. Others help in the dietary and housekeeping departments.

Our patients do attend recreational therapy daily and have a variety of diversions offered to them—such as ball playing and music—but a minimal amount of occupational therapy is offered.

Any of our patients who can benefit from vocational rehabilitation services are referred to that service for assistance early in their hospitalization.

Our patients are entitled to return to this hospital on an outpatient basis if they so desire and this opportunity is offered to each. We also refer some of our patients to mental health clinics, councils on alcoholism and other community services.



Difficult Legal Problem

As Solicitor of the Davidson County Recorder's Court, we have many cases of drunkenness, domestic difficulties, assaults, etc. which involve people who claim to be alcoholics or who appear to be alcoholics. This is a most difficult legal problem to deal with and I would appreciate any literature you might have which I could use to secure information on the nature and curability of alcoholism.

Hubert E. Olive, Jr.
Lexington, N. C.

Well-Traveled

I have received *Inventory* for approximately six years and have come to think about it as an old friend. When I'm through with each copy, I loan it to several friends in the A. A. group to which I belong, with strict orders that it be returned. Then I send it to a dear A. A. friend in England who, I understand, passes it around his small A. A. group. Fortunately it is put together sturdily to withstand the rigor of all this traveling.

Thank you for making *Inventory* available. It is of inestimable value to many of us in A.A.

Anonymous
Greenwich, Conn.

Workshop Material

Concord Presbytery is planning a one-day workshop for ministers, physicians, nurses and other related professional persons. The theme for the session is "The Minister and the Doctor Working Together." We are trying to secure materials that will be helpful for all concerned, who seek to minister to the "whole man." Would it be possible to secure some back copies of *Inventory* (Vol. 15, No. 4) and any other material that you could provide that would be of help to such a group?

George S. Calhoun, Minister
Poplar Tent Presbyterian Church
Concord, N. C.

Sanford A. A. Group

I would like to request 25 copies of each printing of *Inventory* to be distributed to the members of the Central Carolina A. A. Group in Sanford.

I find *Inventory* most informative and am sure that, through A. A., it will reach many families who have need of knowledge of alcoholism.

Anonymous
Sanford, N. C.

Helpful To Program

We are beginning a program for alcoholic patients who are currently not on a regular alcoholic ward but who are on a tuberculosis ward.

In looking through the literature and in discussions with the social workers on the alcoholic wards, they recommended your magazine, *Inventory,* which they have been using successfully, to me.

I believe the topics covered in *Inventory* will be very helpful to our program.

Abe J. Sass
Psychiatric Social Worker
NAPA State Hospital
Imola, Calif.

Imaginative and courageous activities in the areas of the control and prevention of alcoholism and other alcohol problems are indicated if any real long-range impact on alcoholism rates are to be expected.

COMMUNITY ACTION for the CONTROL of ALCOHOLISM and ALCOHOL PROBLEMS

By WILLIAM L. HALES, M.P.H.

ASSOCIATE DIRECTOR
CHARLOTTE COUNCIL ON ALCOHOLISM
CHARLOTTE, N. C.

IF we are to be effective in developing community action for the control of alcoholism and alcohol problems, I think it is imperative that we explore the possibility of change in our emphasis—which in itself requires community action. More simply, I do not believe we can ever effectively control alcoholism and its related problems until we make an honest assessment of our goals and objectives in the light of standard public health procedures.

You may ask, "Can a change in emphasis be made?" I think the answer is yes and I think alcoholism programs have developed to the point that they command sufficient support to institute such changes.

Basically, there must be a shift from our concern for the *individual* alcoholic to concern for *all* alcoholics and from there to a concern with the *alcoholisms*. Too much of the emphasis on alcoholism and alcohol control programs has been centered around the individual and not around his environment. Our primary interest must be redirected to the *total* and away from the *singular,* even though the singular is a part of the totality. This is not to infer that our efforts to treat the alcoholic should

diminish. Dr. Seldon D. Bacon, director of the Rutgers Center of Alcohol Studies, in his keynote address to the fourteenth annual meeting of the North American Association of Alcoholism Programs in 1963 at Miami Beach, clearly indicated that we are going deeper and deeper in the hole with our present emphasis. He presented facts and figures to demonstrate that from 1940 to 1960 we have been losing ground, even though better and more effective techniques of diagnosing and treating alcoholism were developed during this period. Dramatic proof, to me at least, that alcoholics are being created faster than we can treat them. The necessity for a change was further pointed out by Dr. Edward G. McGavran, former dean of the School of Public Health at the University of North Carolina, when he stated: "There is no evidence that control or eradication of any disease has been accomplished by the approach; procedures, techniques and activities directed at early diagnosis and treatment of disease in individuals."

If we are to develop community action programs, then first we must be aware of certain facts. While interest in alcoholism is far greater than it was twenty years ago, it can be questioned whether or not there is sufficiently rapid expansion and growth of programs and public interest in this area. Concern about alcoholism and support for efforts to cope with it still are at a beginning level in most parts of this country. We do not see the broad public and professional interest and activity that characterizes other health areas. Alcoholism today holds the devious distinction of being the fourth major public health problem in this country, and has social implications that adversely affect nearly every facet of our society. Yet, there are, unfortunately, altogether too many of our people (even some in high positions) who are seemingly blind to the problem.

Alcoholism is th

Recognizing these facts, then where do we begin? We begin by realizing there are three things about every community that indicate it can do something about alcoholism.

1. The community has persons who suffer from alcoholism in it. Their sickness affects the family, legal and economic life of the community. It costs the community money, complicates its machinery for law enforcement and causes it untold pains. The community reacts by either accommodating itself to the problem by including it in what is accepted, or by acting to bring about a correction. It would seem obvious that no community would accept the destruction of alcoholism as normal.

2. The community has resources to help these persons. To quote from the film *To Your Health*: "There are doctors and nurses who understand his illness and can help him . . . there are persons whose understanding comes from experience, Alcoholics Anonymous." There are, of course, religious and other groups who can help him and his family deal intelligently with the problem.

3. The community has "teachers" and the means of communication necessary to educate itself about alcoholism and persons to lead it in appropriate action. The leaders have access to members of the community through accepted ways of expressing ideas, molding public opinion, and getting across relevant facts.

You may ask, "How do these three

factors relate to community action in handling the problems of alcoholism?" The answer will depend on whether community action means: (1) someone *acting upon the community* to achieve the desired results of providing treatment, education, change of attitude, motivation to treatment and prevention or (2) *the community itself acting* to bring about these objectives. The second should provide the most permanent results since it secures continuing participation with the least amount of external manipulation and supervision. This is not to preclude outside stimulation in the initial efforts.

Now to the heart of the matter. How does a community start? Where does it begin? It begins, or takes its first organizational step, when one intelligently concerned person sits down with a few others and begins to examine the implications of alcoholism and related problems and to plot some strategy—strategy tailored to the needs of their particular community—for dealing with it. They study the ways in which the problem affects their local situation. They get consultation from those who can help evaluate their need. They develop a program of action. They begin to, and this is most important, talk the same language which should include:

1. Alcoholism is an illness. This gives the community a more promising approach to the problem.

2. The person suffering from the illness can be helped and is worthy of help. Being an illness that can be diagnosed and successfully treated helps alleviate the stigma of "moral disgrace" associated with alcoholism. It also allows a community to replace with hope its feeling of despair about the patient who never seems to respond to the *wrong treatment.*

3. Alcoholism is a public problem and a public responsibility. This places alcoholism in its proper perspective and becomes a matter of urgent action to contain its destructiveness and save society as well as the individual from its devastation. That it is the nation's number four health problem raises it from the category of an occasional accident to a spreading malignant cancer of the body politic.

4. The controversial questions of social drinking versus abstinence, moderation versus drunkenness, and legal liquor sales versus prohibition are simply not apropos if alcoholism is the illness we have said it to be and responds to treatment known to be effective.

With these basic concepts, then, the organized community efforts begin to ask other persons and organizations to do something about alcoholism, to do more of the right things, to do the things that have some promise of success. The spouse, the family, the minister, the church, the teacher, the doctor, the hospital administrator, the social worker, the law enforcement officer, the wet, the dry, the judge, the employer, etc—all can do something about the problem within their own range of activities.

At this point may I add that the most frustration I have experienced in my eight years in the field has not come from the person with alcoholism nor from his family. It has

come from professional persons in positions of authority who refuse to accept any responsibility in this field. This might well be classified as "moral irresponsibiliy."

With what we have previously discussed one might say that community action *properly begins with self-education* of the group that has chosen to become involved with the problems of alcoholism and that community action *properly develops* from the interest of those involved and is a combination of an understanding of alcoholism, a recognition of the local problems, and a proper use of community educational and treatment resources by concerned, informed leadership engaged in action which they have chosen for themselves.

In conclusion I have attempted to point out that community action for the control of alcoholism and alcohol problems involves some basic concepts of community organization that have proven effective and to illustrate the necessity of a re-emphasis in alcoholism programming. Specialized alcoholism treatment facilities cannot be expected to have any real long-range impact on rates of alcoholism. There must be imaginative and courageous activities in relation to the control and prevention of alcoholism and other alcohol problems. A start in this direction could be something seemingly insignificant, like vocabulary. What would the impact in this area of mental health be if all persons involved would begin to use such terminology as intoxicated rather than drunk? Inebriate in the place of drunkard? Under the influence instead of drunkenness? That a person *suffers from alcoholism* rather than a person *is an alcoholic?* I am not sure what effect there might be but I *am* sure that it would be a giant step in the right direction.

COMMUNITY RESPONSIBILITY

CONTINUED FROM PAGE 11

most difficult to secure while criminal commitment is so flagrantly dispensed in an attempt to curb the deviate or antisocial activity of the alcoholic and chronic police case inebriate for simple intoxication in itself.

In summation, it might be stated that there have been three artificial divisions in the field of health which contribute to the lack of effective alcoholic rehabilitation. Cities build hospitals but are not responsible for public health. Counties establish public health departments but do not assume responsibility for overall mental health education and treatment. The State today is largely responsible for mental health treatment and rehabilitation, yet due to the magnitude of the alcoholism problem cannot provide treatment for more than 5 to 10 per cent of those who need interruptive inpatient treatment. This treatment is largely wasted for lack of follow up on a local level.

Despite these overall handicaps, the proper cooperation of the community resources and the state hospital system could achieve a far more effective treatment program for the family and the alcoholic. There is no chance that such a program will occur in the foreseable future as a result of the cooperative efforts of the private practice of medicine. If it does occur it will be through the cooperative efforts of local, private and public agencies working in concert with the cooperative support of the state hospitals acting as an extension of local services or providing services which are not otherwise available.

In one sentence: Alcoholism rehabilitation is a responsibility of the community, too, not the state alone.

VOL. 16, NO. 2 **INVENTORY** OCTOBER-DECEMBER, 1966

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Only significant social bonds within the small groups of our society are capable of providing the stability that individuals need, whether this comes from family, friends, church, work or others.

The Group Context of an Individual Problem

By WALTER J. CARTWRIGHT, Ph.D.

AMERICANS are felt to have a penchant for measuring the importance of nearly anything by its cost. If the price tag is high, it is either outstanding or terrible! Such a measurement lists alcoholism as the number three or number four health problem of the nation. It is, in addition, a focus of current attention because of its association with other social problems.

> . . . In terms of its consequences—poverty, unemployment, homelessness, divorce, automobile accidents, and physical disorders—the excessive use of alcohol is one of the major concerns and problems of Western Society.[1]

It has been estimated that the annual losses sustained from the use of alcohol in the United States is at least $765,000,000 in lost wages, crime, accidents, hospital and medical care, and maintenance of drunken persons in local jails.[2] Were the implications of this cost merely economic, it might be argued that a nation as wealthy as the United States could afford it. Added to such economic loss, however, as Cole and Miller state:

> Other significant losses are found in the waste of manpower, in broken homes, highway accidents and deaths, losses of ambition and and motivation, and the tensions, heartaches, and disappointments that follow in the trail of excessive use of alcoholic beverages.[3]

No further effort will be made here to tabulate such items statisically. It is necessary, however, for us to note that the problem constituted by the alcoholic and the problems faced by the alcoholic as an individual are interwoven with such areas of social concern as mental health, the family, the industrial order, and crimes against persons and property. In the nine terms in which the author has taught a course in *Social*

This paper was the closing address of the Second Annual West Texas Conference on Alcoholism, sponsored by the Texas Commission on Alcoholism in cooperation with the Extension Division of the University of Texas and Texas Technological College where it was held in August of 1965. Its author, Dr. Cartwright, is an associate professor of sociology at Texas Technological College, Lubbock, Texas.

Problems at Texas Technological College, the most frustrating experience for college sophomores has been the ultimate inability to separate these problems and deal with them one at a time. The multi-problem family and the multi-problem individual are realities difficult to evade. It is possible, instead, to examine the relationship of alcoholism to other social problems in terms of the sociological concepts of (1) role impairment, (2) culture, and (3) social control.

Role Impairment. For the sociologist the term role includes the behavior expected of an individual as an occupant of a particular position in society. Although able to perform the expected role under normal conditions, the individual may not, because of alcohol, be able to do so. An obvious reference to such role impairment is contained in the warning posted on Texas Highways by the State Highway Department: "If you drink, don't drive." Although a person might carry in his pocket an official license to indicate he has the motor skills and other qualifications to function as a driver of a motor vehicle on the public roads, even moderate drinking will lessen his ability to perform this role in a safe manner.

While motor impairment is most obvious in the individual who is charged with "Driving While Intoxicated" (DWI), "role impairment of many kinds may result . . . from . . . drinking and certainly from alcoholism."[4] The high degree of skill demanded in modern industrial occupations is vulnerable under alcoholic excesses. Even more, however, modern factories need a dependable labor supply. Absenteeism and frequent changes of jobs are problems to factory discipline and of no little economic consequence to the industry and society. In the words of Charles A. Beard: "Grass may grow and sheep may graze if the peasant lies drunk under the hedge occasionally, but the wheels of mils cannot turn steadily if boiler stokers must have frequent debauches."[5]

Certainly jobs can be and frequently are lost because of alcoholism, but it is not implied that this connection between alcoholism and the job is a one-way relationship. Rather the kind of work known by most Americans is carried on amid frustrating and tension-creating circumstances which may be becoming more rather than less acute.

> Men are typically alienated from their work, bored with too much leisure, discouraged by too little, unhappy for many reasons in their man-woman worlds, collectively fearful of the possibility of nuclear holocaust, and in surprising numbers are in manifest degree mentally ill. The temporary escape through alcohol is to many people a more or less 'rational' way of 'learning to live with it all.' Thus the 'social drinker' is born.[6]

Gains Greatest Reward

The potential alcoholic is the individual who gains the greatest reward from this experience of escape. A circularity arises in the relationship between the job and alcoholism that may be illustrated in the following sequence: Frustrations on the job may cause a man to seek relaxation and forgetfulness in alcoholic indulgence. If continued long enough or often enough (as in a case of true alcoholism), this can lead to the loss of a job. Unfortunately this change does not eliminate economic frustrations, nor does a bad job record produce good recommendations for another job. In the face of this new blow the alcoholic is able to turn again to excessive drinking for so-

lace, frequently not hesitating to deprive himself or his family of food in order to provide a supply of drink. The circularity of these interrelationships is not an issue at this point; rather stress is placed upon the contribution that alcoholism makes to other social problems through impairment of the individual's ability to perform acceptably a role expected of him. "Whereas he may have increased his drinking in order to feel more adequate in a difficult job, he reaches the point where he cannot hold any job at all."[7]

Even when allowance is made for the same circularity of causation, role impairment associated with alcoholism is a factor in the problems of the family, namely family unhappiness, friction, and finally divorce. (It is sometimes asked: does a man drink to escape a nagging wife or does the wife nag because of a drinking husband? Who knows? Clearly, the two problems exist together.) The children of such a "broken home, whether or not it is defined as such by a formal divorce, will have a higher than average association with juvenile delinquency.[8] (This is an empirical relationship which may or may not have causal significance. Once again, the problems exist together.) And of course, a sizable proportion of crime and juvenile offenses are committed by persons who are "under the influence."

Culture. The performance of the individual role, however, must be viewed from the perspective of the general culture within which it is performed. Variability of the rates of alcoholism among separate nationalities and diverse ethnic groups have been frequently noted; attempts to explain these variations on the basis of biological (or racial) differences have failed. For example, it was pointed out long ago that alcoholism rates are 75 times as high among the Irish-Americans as among the Jewish-Americans.[9] The Jewish immigrants to the United States were such a heterogeneous people that there is no bio-racial basis for crediting them with immunity from alcoholism.[10]

> Clues to the reasons for this extreme variability can be found in the way in which the drinking patterns fit into the overall culture patterns. When drinking is associated with manliness and virility—as among the Irish, the French, and even in the United States—alcoholism appears to be common.[11]

If long drinking bouts are socially admired and it is a sign of prowess to "drink others under the table," a high rate of alcoholism is to be expected. If, however, drinking is frowned upon except at meals or on highly ritualized occasions, alcoholism is much less. The comparison of France and Italy is instructive at this point. Despite almost universal drinking in both countries, alcoholism is extremely high in France and very low in Italy.[12] Wine is a part of the pattern of meals among the Italians who do not drink often apart from meals. It is the pattern of freely partaking of drink throughout the day separate from meals which produces the alcoholism of the French.

Some of the most interesting recent studies of alcoholism have been attempts to make cross-cultural studies from the perspective of anthropological investigations.[13] One such study of the place of alcohol in primitive societies takes the position that the primary function of alcohol is the reduction of anxiety. When, however, excessive drinking reduces social order along with anxiety, the society attempts to control the relax-

ation of social standards by punishments for alcoholic excesses. The use of materials from the Cross-Cultural Survey at Yale University indicates variable patterns ranging from general drunkenness to general abstinence. Elements in the culture independent of alcohol determines what the response to alcohol will be.[14] One verified theorem in the study indicates that the more primitive the subsistence economy, the greater will be the degree of insobriety permitted. Beard's peasant supervising grazing animals is not greatly handicapped by his drunkenness. Insobriety in a modern industrial society is particularly inappropriate at this point.

Earlier, comment was made of the difference between the rates of alcoholism for Irish and Jewish populations in America, a point that has been frequently recognized in the literature on alcoholism. While the proportion of total abstainers is lowest among Jews of all major groups in the United States, so also is the alcoholism rate. Among the Jewish devout, "the cultural tradition locates the act of drinking squarely in the network of sacred ideas, sentiments, and activities. The act of drinking is primarily of an expressive, communicative, and religiously symbolic character."[15] By voicing a prayer or benediction before each glass, the Orthodox Jew makes his drinking a part of the fabric of worship.

Along with this symbolic use of drinking there is a strong negative evaluation of drunkenness as an outgroup characteristic. The author quoted above cites in another place[16] a Yiddish folksong which stigmatizes the drunkard as totally unacceptable and un-Jewish. It should be clear that the rejection of drunkenness as a form of behavior is emphasized not for the sake of current drinkers but for the children of the day including the very youngest. It serves not to "nag" the drinker but to indoctrinate the young. In the investigation covered by the study,[17] informants termed the folksong, "Shikker iz a Goy" (or Drunken is a Gentile), a lullaby sung by Yiddish mothers to a young child in her arms or in a cradle. For the group within which one is warmly received, the song builds an emotional bond while rejecting the unacceptable behavior of the out-group. Having heard the identification of sobriety with Jewishness from early childhood and pronouncing a prayer or benediction before partaking of any drink, the devout Jew finds it almost impossible to get drunk. His worth as an individual demands sober behavior.

Contrast the above with the Irish tradition of proving manliness, not by sobriety, but by excessive drunkenness and wild behavior in the process, perhaps using a shillelagh freely in any incidental fighting. The wide difference in rates of alcoholism that has been often noted is a logical correlate of such cultural variation.

Despite a proportion of abstainers in America, something under forty per cent but varying from group to group,[18] there is a strong identification of drinking with manliness, witness the fictional cowboy hero or the tough private-eye of television who can toss off repeated drinks without hesitation and can follow it up with his best display of wit and/or physical prowess. One is led to the conclusion that only the weakling is overcome by this and that a "real man" is unaffected by excessive drinking, an unjustified assumption at best. The widespread encouragement toward the cocktail hour and the custom of drinks over business appointments are said to make the

traveling salesman "particularly prone to alcoholism,"[19] especially as he faces frequent loneliness and separation from meaningful primary relationships. With such availability of alcohol there is no accompanying tradition of sobriety to give support to the salesman far from home; certainly there is no American lullaby to remind him of the superiority of sobriety. Unfortunately, the wet-dry split in American life separates the virtues of sobriety and a friendly cup so far from one another that they may not find residence in the same person. "The tolerance in this country for drunken behavior and the social pressure for drinking are perhaps the two greatest factors which have led to this overemphasis on drinking," states Dr. Marvin A. Block[20] of the American Medical Association's Committee on Alcoholism and Addiction.

The Third Factor

Social Control. The third of the social factors in the use of alcohol may be termed social control. Acceptable behavior in any population is not only regulated by the teaching of patterns of proper behavior early in the experience of the individual but also by social reinforcement in terms of social control by which society regulates the behavior of its members. Any weakening of the ability of society to so regulate its members will indicate a rise of social problems on the one hand and the disintegration of society on the other. The eminent French sociologist, Emile Durkeim, wrote a classic study of this basic issue in *Suicide.*[21] He noted the fact of variation in rates of various pathological conditions and asked particularly why suicide rates should vary so much from place to place. After ruling out the relevance of race, geography, climate, etc. as explanations, he settled upon the identification of the individual in his group as the factor which restrained the individual from tendencies of self-destruction. Whether or not one accepts a Freudian wish for destruction (death wish), it is evident that every individual is at times tired, despairing, and may wonder if the struggle to go on is worth it all. At these moments any normal individual in his despair may easily ask, why not end it all? Only strength of the social bonds restrains him, particularly where there are people depending on him. Hence Durkeim was able to show that suicide rates are lower among the married than among the single, lower in rural than in urban areas, and lower in highly integrated groups than in groups with less mutual dependence. The above is an inadequate summary of the Durkeimian argument but it does indicate that suicide is basically a study of social cohesion or "the tie that binds" the individual in his group.

In alcoholism, a similar tendency toward self-destruction may be seen.[22] If tensions are great or problems are hard to face, one may decide not to face them. The euphoria or anesthetic quality of alcohol for a few minutes provides the escape. When longer escape is needed, continuing intoxication is possible. The inability to face life without the morning eyeopener is a mark of the confirmed alcoholic. To the degree that this dependence of the alcoholic is continuous he has achieved the aim of the suicide. Like the suicide he can be restrained from this self-destruction tendency only by incorporation within a meaningful social experience. It should not be said that the group creates either suicide[23] or alcoholism but rather that weakness in this social bond

may allow either to develop. Raab and Selznick speak of family disorganization and neighborhood disorganization as "specific risk conditions"[24] or as places where one may look to gain understanding of any social problem. It is in the lessening of the social bond of which these are but two specific examples that the incidence of social problems is to be found.

Among the efforts that are not oriented toward medical, chemical, or psychiatric treatment are the most important programs for helping the alcoholic make use of the social bonds. The work of Alcoholics Anonymous enables a man with a problem to find a place in a new group where he is understood and accepted with both his weaknesses and his strengths. This mutual helpfulness is, of course, the work of amateurs that suffers if judged by professional standards; yet it has been said that the rate of success of the program "is spectacularly higher than has been achieved by any other means."[25]

Further recognition of the importance of group relationships is to be seen in all the forms of counseling which recognize the need for counsel on the part of the family as well as the alcoholic. Community services are increasingly being termed "family services" because of the need to treat more than the one "sick" person. The recognition of churches of the need to become a "redemptive fellowship" makes use of the group bonds of understanding and acceptance that are crucial to the alcoholic. By no means of least importance is the growing recognition by industry and business that key members of its staff seek refuge from pressures in excessive use of alcohol. It may even be that the especially gifted person is peculiarly subject to a danger that the dullard and the plodder never knows. The demand for early treatment of the problem is presented by management not for the purpose of punishment but in order to salvage the gifted worker and keep him a functioning member of the business or industrial team.[26]

Of the terms we have used, role impairment is almost a definition of alcoholism since the "patient" is "sick" only when his dependence upon alcohol has begun to interfere with his normal participation in society. In the perspective of long range programs of cure or control, it is to be hoped that cultural norms which recognize that sobriety is an acceptable form of behavior may become more acceptable even among those persons who feel no personal inclination to accept abstinence as a way of life. It follows, of course, that an attempt by the non-drinker to understand the problems of the alcoholic is the other side of the coin. Divergence of opinion at this point is so great that there is little likelihood of early agreement.

Meaningful Social Participation

Within the group context of social participation, however, many promising forms of dealing with alcoholism are being tried. The purpose of this paper is not to select one among these as "best" but to point out the common strength which lies in all of them. In a heterogeneous society like that of the United States, a nationwide pattern of behavior is not to be expected. As culture-wide bonds become weaker, conflicting, or less clear, patterns of individual deviation are increasingly possible. Only significant social bonds within the small groups of our society are capable of providing the stability that individuals need, whether this comes from family, friends, church, work,

or others. In our legal system and in our moral codes the concept of "individual responsibility" has an unfortunate tendency to shift all responsibility from the group to the individual. If he is an alcoholic, the individual is seen as "weak," as "sinful," as "guilty," or, more recently, as "sick." In each case the burden of responsibility rests upon the deviant individual. Whether composed of abstainers or social drinkers, the group has shifted total responsibility for the behavior of the deviant member to his individual shoulders; if he is weak, sinful, guilty, or sick, it is not our fault! Implicit rejection by the group only compounds the problem of the alcoholic. Obviously he needs support or he would not have sought it in alcoholic euphoria. This need does not mark him as different since all persons need support from others although perhaps with varying degrees of intensity. A realistic program either of treatment or prevention must provide a social experience that supports rather than merely condemns the alcoholic. While such social cohesion may lead to the "healing" or restoration of the alcoholic to normal experience, it is primarily in the prevention of the problem through early recognized standards of proper behavior supported by group approval that meaningful social participation can make its greatest contribution.

References

1 Russell R. Dynes, Alfred C. Clarke, Simon Dinitz, and Iwao Ishino, *Social Problems; Dissensus and Deviation in an Industrial Society.* New York: Oxford University Press, 1964, p. 523.

2 George N. Thompson, "The Psychiatry of Alcoholism," in George N. Thompson (Ed.), *Alcoholism.* Springfield, Illinois: Charles C. Thomas, Publisher, 1960, p. 453.

3 William E. Cole and Charles H. Miller, *Social Problems: A Sociological Interpretation.* New York: David McKay Company, Inc., 1965, p. 247.

4 *Ibid.,* p. 254.

5 Charles A. Beard, "The Development of Social Thought and Institutions: Individualism and Capitalism," in *Encyclopedia of the Social Sciences.* New York: Macmillan, 1930, Vol. I, p. 149.

6 John F. Cuber, William F. Kenkel, and Robert A. Harper, *Problems of American Society: Values in Conflict.* New York: Holt, Rinehart, and Winston, 1964 (Fourth Edition), p. 350.

7 Harry C. Bredemeier and Jackson Toby, *Social Problems in America: Costs and Casualties in an Acquisitive Society.* New York: John Wiley and Sons, 1960, p. 156.

8 Earl Raab and Gertrude Jaeger Selznick, *Major Social Problems.* New York: Harper and Row, 1964 (Revised Edition), p. 62-64.

9 A. Meyer, "Alcoholism as a Psychiatric Problem," in H. Emerson (Ed.), *Alcohol and Man.* New York: The Macmillan Col, 1932, Chapter II.

10 Charles R. Snyder, "A Sociological View of the Etiology of Alcoholism," in David J. Pittman (Ed.), *Alcoholism.* Springfield, Ill.: Charles C. Thomas, Publisher, 1959, pp. 32ff.

11 Paul N. Horton and Gerald R. Leslie, *The Sociology of Social Problems.* New York: Appleton-Century-Crofts, 1965 (Third Edition), p. 559.

12 Horton and Leslie, *loc. cit.*

13 David J. Pittman and Charles R. Snyder (Eds.), *Society, Culture, and Drinking Patterns.* New York: John Wiley and Sons, 1962, Section I.

14 Donald Horton, "The Functions of Alcohol in Primitive Societies: A Cross-Cultural Study," *Quarterly Journal of Studies on Alcohol,* Vol. IV, No. 2 (1943), pp. 292ff.

15 Snyder, *op. cit.,* pp. 35-36.

16 Charles R. Snyder, "Culture and Jewish Sobriety," in Marshall Sklare (Ed.), *The Jews.* Glencoe, Illinois: The Free Press, 1950, pp. 560-594.

17 Ibid., p. 597.

18 Dynes *et al, op. cit.,* p. 528.

19 Louis Cassels, "Can *You* Help the Problem Drinker," in *Sales Management,* Vol. 81, No. 5 (August 15, 1958), pp. 29ff.

20 Marvin A. Block and Fred V. Hein, "How Teens Set the Stage for Alcoholism," in *Today's Health,* Vol. 40, No. 6 (June 1962) pp. 69.

21 Emile Durkheim, *Suicide: A Study in Sociology.* New York: The Free Press of Glencoe, Illinois, 1951.

22 Charles A. Snyder, "A Sociological View of the Etiology of Alcoholism," in Pittman, *op. cit.,* p. 32.

23 No consideration is given here to the special case of altruistic suicide where the great strength of social cohesion may lead to self-sacrifice for the common good. See Durkheim, *op. cit.,* pp. 217-240.

24 Raab and Selznick, *op. cit.,* pp. 21-24.

25 Horton and Leslie, *op. cit.,* p. 558.

26 Cassels, *op. cit.,* p. 31.

DIRECTORY OF OUTPATIENT FACILITIES

for

ALCOHOLICS AND / OR THEIR FAMILIES

Competent Help Is Available At The Local Level

Key to Facility and its Service

***Local Alcoholism Programs**

for
(Alcoholics and Their Families)

—Education
—Information
—Referral

†Mental Health Facilities

for
(Alcoholics and Their Families)

—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

—Outpatient Treatment Services

ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: 704-252-8748.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* R. J. Cook, Executive Director; Room 802, N. C. National Bank Building; Phone 919-228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m. - 4:00 p.m.

BUTNER—

‡*Aftercare Clinic; John Umstead Hospital;* Hours: Mon. - Fri., 9:00 a.m. - 4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro; Phone: 919-942-1089 or (if no answer) 919-942-1930.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: 704-375-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon. - Fri., 8:00 a.m. - 5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 316 E. Morehead St.; Phone: 704-334-2834.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

†*Aftercare Clinic*; Watts Hospital; Hours: Tues. and Fri., 2:00 - 5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; 919-682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m. - 12:00 noon. Thurs., 2:00 - 4:00 p.m.

**Wayne Council on Alcoholism;* Durwood Howard, Director; P. O. Box 1598; Phone: 919-735-7033.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 919-275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Executive Secretary; P. O. Box 2371; 915 Dickinson Ave.; Phone: 919-758-4321.

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone; PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 158 Bypass W; P. O. Box 1174; Phone: 919-438-3274 or 919-483-4702.

HENDERSONVILLE—

Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: 919-692-8118.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 919-883-2794.

LAURINBURG—

**Scotland County Citizens Council on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; P. O. Box 1229; Phone: 919-276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon. - Fri., 2:00 - 4:00 p.m.

**Burke County Council on Alcoholism;* Grady Buff, Educational Director; 211 N. Sterling St.; Phone: 704-433-1221.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 919-637-5719.

*†*Psychiatric Social Service,* Craven County Hospital; Phone: 919-638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: 704-464-3400.

PINEHURST—

Sandhills Mental Health Clinic; Box 1098; Phone: 295-5661.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00 - 4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County,* Inc.; Wake Memorial Hospital; Phone: 834-6484; Hours: Mon. - Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 919-633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholism Program;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: 919-692-6631.

WADESBORO—

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 704-694-2711.

WILKESBORO

Wilkes County Council on Alcoholism; William S. Call, Executive Director; 100 Bridge St.; Phone: 919-838-6046.

WILMINGTON—

†*Mental Health Center of New Hanover County;* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; P. O. Box 1435; Phone: 919-736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon. - Fri., 8:00 a.m. - 5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

**Wilson County Council on Alcoholism;* W. H. Jennings, Director; Room 208, 116 S. Goldsboro St.; Phone: 919-237-0585.

WINSTON-SALEM—

*†*Alcoholism Program of Forsyth County;* Robert Charlton, Educational Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: 919-725-5359.

EDUCATION AND INFORMATION SERVICES

INVENTORY—quarterly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory,** go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

Consultant Service—for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

Education Division, N. C. Department of Mental Health
P. O. Box 9494
Raleigh, N. C. 27603

Second - Class
Postage Paid at Raleigh, N. C., 27602.